Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF NURSING,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 14-0380 BN
	)	
ERICKA MOORE,	)	
	)	
Respondent.	)	

DECISION

Cause exists to discipline the licensed practical nursing ("LPN") license of Ericka Moore because she failed to institute cardiopulmonary resuscitation ("CPR") or call 911 for a resident in her care who had stopped breathing and felt cool to the touch, she had failed on other occasions to perform the duties of an LPN, and she had been placed on the Employee Disqualification List ("EDL").

Procedure

On March 25, 2014, the State Board of Nursing ("the Board") filed its complaint asking this Commission to find that cause exists to discipline Moore's license as an LPN. Moore was served with a copy of the complaint and our notice of hearing by certified mail on April 3, 2014. On May 12, 2014, the Board filed a motion for default decision. Moore filed a response to the complaint on May 27, 2014. We denied the Board's motion for default decision on May 30, 2014.

On August 28, 2014, the Board filed an amended complaint alleging additional cause for discipline because Moore had been placed on an EDL. Although we gave Moore until September 9, 2014 to respond to the motion, she did not do so. We granted the Board's motion on September 11, 2014 and deemed the amended complaint filed as of August 28, 2014.

On September 17, 2014, we held a hearing. Ian Hauptli represented the Board and Moore represented herself. The matter became ready for our decision on November 19, 2014, when Moore's written argument was due.

Commissioner Nicole Colbert-Botchway, having read the full record including all the evidence, renders the decision. Section 536.080.2, RSMo 2000;[1] ***Angelos v. State Bd. of Regis'n for the Healing Arts***, 90 S.W.3d 189 (Mo. App. S.D. 2002).

Findings of Fact

1. The Board is an agency of the State of Missouri, created and established by Missouri law for the purpose of executing and enforcing Chapter 335, the Nursing Practice Act.

2. Moore is licensed by the Board as an LPN. Moore's license was current and active at all relevant times.

3. At all relevant times, Moore was employed by Green Valley Nursing and Rehab ("the Facility") in St. Louis, Missouri, as an LPN.

Patient I.R.

4. On January 2, 2013, Moore was working an early morning shift at the Facility.

5. One of the patients in Moore's care that morning was I.R.

6. I.R. had been diagnosed with hypertension, moderate aortic insufficiency, congestive heart failure, and atrial fibrillation, among other medical conditions.

[1] Statutory references, unless otherwise noted, are to the 2012 Supplement to the Revised Statutes of Missouri.

7. Before January 2, 2013, I.R. had been placed in "full code" status. "Full code" status means that all measures to sustain life are to be undertaken, as opposed to a "do not resuscitate" order.

8. At around 3:15 A.M. on January 2, 2013, Moore checked I.R.'s status and found I.R. sleeping, her breathing evidenced by her chest rising and falling.

9. At around 5:20 A.M. on January 2, 2013, Moore checked I.R.'s status and found that she was not breathing and was cool to the touch.

10. After discovering I.R.'s condition, Moore did not perform CPR on I.R., nor did she call 911. Instead, she contacted I.R.'s daughter at 5:23 A.M., and Green Valley's administrator at 5:30 A.M.

Other Actions and Omissions

11. On January 1, 2013, Moore failed to report and document that a resident in her care was missing a Wanderguard, a device to prevent resident elopement.

12. On January 2, 2013, Moore failed to chart behavioral logs, failed to complete work sheets, failed to check charts, and failed to file medication administration records in residents' charts.

13. On January 22, 2013, Moore failed to document a patient's temperature and vital signs for 72 hours after the patient had been given a vaccination.

Placement on the EDL by DHSS

14. On February 24, 2014, Moore was placed on the Employment Disqualification List for one year by the Missouri Department of Health and Senior Services ("DHSS"). She was placed on the list for neglect of a resident of a skilled nursing facility.

Attempts by the Board's Investigator to Contact Moore

15. On September 4, 2013, the Board's investigator, Danielle Keaton, tried to reach Moore by telephone at the three numbers the Board has listed for her. Two of the numbers were

disconnected. When Keaton reached the third number, for Charlevoix Health Care Center, she was told that Moore did not work there.

16. Keaton then called three persons who had been listed as references for Moore on the Facility's records. When she called the first reference, a recorded message said that the person was unavailable. The second person was not available to take the call, but Keaton left a message for her. The third person's number was no longer in service.

17. Moore returned Keaton's phone call on September 4, 2013. Keaton scheduled a telephone interview with Moore for September 5, 2013, at 8:30 A.M.

18. When Keaton called Moore on September 5, 2013 at 8:30 A.M., her call went through to voicemail, where she left a message for Moore to return the call. Keaton tried to call Moore again on September 6, 9, and 10, 2013, but Moore did not return any of those calls.

19. During this time, Moore had experienced financial problems and had been homeless.

Conclusions of Law

We have jurisdiction to hear the complaint. Section 621.045. The Board has the burden of proving that Moore has committed an act for which the law allows discipline. ***Missouri Real Estate Comm'n v. Berger***, 764 S.W.2d 706, 711 (Mo. App. E.D. 1989). The Board argues that there is cause for discipline under the following provisions of § 335.066:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
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> * * *
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> (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the

> functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;
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> * * *
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> (12) Violation of any professional trust or confidence;
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> (15) Placement on an employee disqualification list or other related restriction or finding pertaining to employment within a health-related profession issued by any state or federal government or agency following final disposition by such state or federal government or agency.

The Board also argues that there is cause to discipline Moore under § 335.066.2(6)(h) RSMo Supp. 2013, which provides:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
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> * * *
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> (6) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct, or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:
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> * * *
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> (h) Failure of any applicant or licensee to cooperate with the board during any investigation[.]

I. Subdivision (5)— Professional Standards

Misconduct and Gross Negligence

Misconduct means "the willful doing of an act with a wrongful intention[;] intentional wrongdoing." ***Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surv'rs v. Duncan***, No. AR-84-

0239 (Mo. Admin. Hearing Comm'n Nov. 15, 1985) at 125, *aff'd*, 744 S.W.2d 524 (Mo. App. E.D. 1988). The Board set out its argument on this issue in part of its brief as follows:

> Respondent made a conscious decision to not follow the treatment plan for a full code patient. She could have begun CPR, or called 911 for emergency services, or performed some other life sustaining measure as required for her patient. Rather than using her nursing skills and performing the treatment required for her patient, Respondent simply contacted the administrator to report that the patient was deceased; making a medical determination she is unqualified to make, *Respondent's actions were* so far below what would be expected of an LPN in terms of what she did in relation to a patient who was discovered not breathing, and is *such a deviation from professional standards, that it demonstrates a conscious indifference to her professional duties and functions as enumerated in Section 335.066.2(5), RSMo.*

Board's Proposed Findings of Fact, Conclusions of Law, and Argument p. 7 (emphasis added). In this paragraph, the Board both accurately summarizes the evidence and describes the nature of Moore's conduct. It also, quite accurately, describes the legal standard, not of misconduct, but of gross negligence. Gross negligence is a deviation from professional standards so egregious that it demonstrates a conscious indifference to a professional duty. ***Duncan***, 744 S.W.2d at 533. The professional standards of an LPN are set out in the definition of "practical nursing" in § 335.016(14), which provides in relevant part:

> "Practical nursing" [is] the performance for compensation of selected acts for the promotion of health and in the care of persons who are ill, injured, or experiencing alterations in normal health processes.

The Board's evidence and argument supports a finding not of willful action with wrongful intention, but of conscious indifference to I.R.'s condition. Moore failed to use her nursing skills to try and revive I.R. and failed to summon emergency help by calling 911 when she discovered that I.R. was not breathing and was cool to the touch. Instead, she simply notified I.R.'s daughter and the Facility's administrator that I.R. was deceased. Given the fact that I.R.'s "full code" status necessarily dictated that Moore should have tried to revive I.R., call 911, or both,

we fully agree with the Board's argument that her failure to do so clearly showed a conscious indifference to her professional duties and functions.

However, the Board pleaded specifically that Moore's actions constituted misconduct, while it pleaded generally (by citing § 335.066.2(5) RSMo 2012 Supp.) that Moore's actions violated all the subcategories (incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty) of paragraph 2(5) of the 2012 statute.

We must evaluate, therefore, whether Moore was given sufficient notice of the Board's gross negligence allegation. To do so, we apply the analysis of ***Moheet v. State Bd. of Registration for the Healing Arts***, 154 S.W.3d 393 (Mo. App. W.D. 2004**).** In that case, the complaint did not specifically allege that the physician committed "conduct or [a] practice which is or might be harmful or dangerous to the…physical health of a patient." Instead, the complaint set out the statute, § 334.100.2(5), containing the allegation and made specific allegations regarding Moheet's behavior, i.e., failed to ascertain an emergency room patient's blood pressure or otherwise examine the patient. ***Moheet***, 154 S.W.3d at 398-99. The Court of Appeals in ***Moheet*** began with the rule of ***Duncan*** regarding the level of pleading required:

> The specificity of charges could be at essentially three levels. The most general is simply a statement that the accused has violated one or more of the statutory grounds for discipline without further elaboration, i.e., he has been grossly negligent. Such an allegation is insufficient to allow preparation of a viable defense. The second level involves a greater specificity in setting forth the course of conduct deemed to establish the statutory ground for discipline. The third level involves a degree of specificity setting forth each specific individual act or omission comprising the course of conduct. Due process requires no more than compliance with the second level.

Moheet, 154 S.W.3d at 398, citing ***Duncan***, 744 S.W.2d at 539. The Court of Appeals found that reciting the statute and setting out the behavior constituting cause for discipline complied with ***Duncan's*** second level of pleading and thus satisfied due process.

In this case, I.R. had already been diagnosed with, among other things, hypertension, a history of moderate aortic insufficiency, congestive heart failure, and atrial fibrillation. She was also the subject of a "full code" order regarding resuscitation. Those background facts, and Moore's failure to do anything besides contact I.R.'s daughter and the Facility's administrator, leads us to find that Moore had failed to care for a person who was ill, injured, or experiencing an alteration in her normal health process. Accordingly, we conclude that Moore is subject to discipline for gross negligence, but not misconduct.

Incompetency

Incompetency is a general lack of professional ability, or a lack of disposition to use an otherwise sufficient professional ability, to perform in an occupation.[2] An evaluation of incompetency necessitates a broader-scale analysis, one taking into account the licensee's capacities and successes. Accordingly, we consider not only Moore's conduct in the death of I.R., but other conduct that the Board complains gives it cause for discipline. In chronological order, those other incidents were:

- January 1, 2013— Moore failed to report and document that a resident in her care was missing a Wanderguard, a device to prevent resident elopement. (ex. 3-3)
- January 2, 2013— Moore had failed to chart behavioral logs, failed to complete work sheets, failed to check charts, and failed to file medication administration records in residents' charts. (ex. 3-2)- when asked about it, said she didn't recall not doing those things, but admitted that she guessed she had not charted matters as appropriate. (tr. 14)

Together, these incidents show that Moore was unable or unwilling to function properly in the profession of licensed practical nursing. Therefore, we find Moore to be subject to discipline for incompetency.

Fraud, Misrepresentation, and Dishonesty

In the same way that the Board alleges gross negligence by quoting § 335.066.2(5), so too does it allege fraud, misrepresentation, and dishonesty by quoting that statute. Fraud is an

[2] ***Tendai v. Missouri State Bd. of Reg'n for the Healing Arts***, 161 S.W.3d 358, 369 (Mo. banc 2005).

intentional perversion of truth to induce another, in reliance on it, to part with some valuable thing belonging to him. *State ex rel. Williams v. Purl*, 128 S.W. 196, 201 (Mo. 1910). It necessarily includes dishonesty, which is a lack of integrity or a disposition to defraud or deceive. WEBSTER'S THIRD NEW INT'L DICTIONARY 650 (unabr. 1986). Misrepresentation is a falsehood or untruth. *Id*. at 1145.

However, the Board provided no evidence showing that Moore perverted the truth about any matter, much less that she did so with the intent or purpose of deceit. Neither did the Board show that Moore committed any sort of dishonesty as the term is defined above, or that she made any misrepresentation.

Summary Regarding Professional Standards

In summary, Moore committed gross negligence and incompetency, but not misconduct, fraud, misrepresentation, or dishonesty. There is cause for discipline under § 335.066.2(5).

II. Subdivision (6)(h)— Failure to Cooperate with Board's Investigation

The Board alleges that Moore failed to cooperate with the Board in that, after initially returning the phone call from the Board's investigator, she failed to participate in a scheduled interview and did not return subsequent phone messages from the investigator. The Board argues that Moore's conduct in this matter constitutes a "failure to cooperate" with the Board. Its brief provides dictionary definitions for "failure" and "cooperate" in support of that argument.[3]

We must agree with the Board. While Moore testified that she was not trying to avoid the calls, but simply had a lot going on during that period of her life, such as having financial problems and being homeless, she was still a licensed professional and had the duties accompanying such licensure. We conclude that her failure to cooperate with the Board's

[3] The Board defined "failure" as an "omission of occurrence or performance" and "cooperate" as "to act in a way that makes something possible or likely; to produce the right conditions for something to happen."

investigation constituted unprofessional conduct. We therefore find cause for discipline under § 335.066.2(6)(h).

III. Subdivision (12)— Professional Trust

The phrase "professional trust or confidence" is not defined in Chapter 335, nor has the phrase been defined in the case law. Absent a statutory definition, the plain meaning of words used in a statute, as found in the dictionary, is typically relied on. *E&B Granite, Inc. v. Dir. of Revenue,* 331 S.W.3d 314, 318 (Mo. banc 2011). The dictionary definition of "professional" is

> of, relating to, or characteristic of a profession or calling…[;]… engaged in one of the learned professions or in an occupation requiring a high level of training and proficiency…[; and]…characterized or conforming to the technical or ethical standards of a profession or occupation….

WEBSTER'S THIRD NEW INT'L DICTIONARY UNABRIDGED 1811 (1986). "Trust" is

> assured reliance on some person or thing [;] a confident dependence on the character, ability, strength, or truth of someone or something…[.]

Id. at 2456. "Confidence" is a synonym for "trust." *Id.* at 475 and 2456. Trust "implies an assured attitude toward another which may rest on blended evidence of experience and more subjective grounds such as knowledge, affection, admiration, respect, or reverence[.]" *Id.* at 2456. Confidence "may indicate a feeling of sureness about another that is based on experience and evidence without strong effect of the subjective[.]" *Id.* Therefore, we define professional trust or confidence to mean reliance on the special knowledge and skills that professional licensure evidences. It may exist not only between the professional and her clients, but also between the professional and her employer and colleagues. *See Cooper v. Missouri Bd. of Pharmacy,* 774 S.W.2d 501, 504 (Mo App. E.D., 1989).

In this case, Moore violated a basic trust that exists between a nurse and her patients—that in a full code situation, she would undertake all measures to sustain I.R.'s life when she

discovered that I.R. had stopped breathing and felt cool to the touch. There is cause for discipline under section 335.066.2(12).

III. Subdivision (15)— Employee Disqualification List

Pursuant to §§ 197.500 and 660.300, DHSS maintains a list of individuals who have been determined to have abused or neglected a patient, resident, or consumer, among other offenses. The acts must have occurred while the individual was employed at a long-term care facility or certain other entities. Pursuant to § 660.315, no person whose name appears on the EDL may be employed by a health care provider.

The affidavit from Patricia Mae Watkins, manager of the EDL unit of DHSS, states that DHSS placed Moore on the EDL for a period of one year for neglect of a resident of a skilled nursing facility. Moore admitted that she was placed on the EDL. Tr. 11.

Section 335.066.2(15) states that a nurse may be disciplined for being placed on this list. Moore was placed on the EDL. Therefore, there is cause for discipline under § 335.066.2(15).

Summary

Cause exists to discipline Moore under § 335.066.2 (5), (6)(h), (12) and (15).

SO ORDERED on March 17, 2015.

\s\ Nicole Colbert-Botchway
NICOLE COLBERT-BOTCHWAY
Commissioner